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Prevention of Gender Based Violence in Uganda

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Fieldwork Report Summary

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Abstract

Gender based violence is a problem worldwide with prevalence anywhere between 13 to 70%(WHO, 2013). Global figures show that 35% of women throughout the world experience intimate partner violence or non-partner sexual violence in their lifetime (WHO, 2013). According to World Health Organization (WHO), intimate partners commit 38% of women murdered. The statistics show that women from countries like Uganda have a 60% incidence of physical or sexual violence by an intimate partner. The government of Uganda and the WHO are well aware of the seriousness of this problem. The purpose of this paper is to explain the seriousness of this problem worldwide but more so in the country of Uganda and their readiness assessment of this public health problem. It also will explain the development of a project by the WHO in Uganda called Management of Sexual Gender-Based Violence Survivors/Victims. A manual was developed to provide the Ministry of Health with national standard materials for training health care workers and other relevant stakeholders involved in the management of Sexual Gender-Based Violence Survivors/Victims and as a tool as the basis for health professionals to respond appropriately to major conditions related to sexual gender based violence (SGBV) (Appendix 1). The goal of the training is to provide health care workers with competencies to manage and respond to SGBV. The tool is to provide a training resource for players in health institutions and organizations involved in training service providers in management of survivors/victims of Sexual Gender Based Violence as a competent of the Minimum Health Care Package-Non-Communicable diseases. And lastly, a summary of recommendations will be presented to continue to prevent and treat gender-based violence (GBV) / and Intimate Partner Violence (IPV).

Introduction

In 1995, the Beijing Platform for Action of the Fourth World Conference on Women called for the elimination of violence against women but also made these recommendations not only calling for the elimination of all forms of violence against women, but more specifically recommended that work be done to:

> Promote research, collect data and compile statistics, especially concerning domestic violence relating to the prevalence of different forms of violence against women, and encourage research into the causes, nature, seriousness and consequences of violence against women and the effectiveness of measures implemented to prevent and redress violence against women. The importance of this policy was to put into practice an adequate understanding of how practitioners work effectively with the individual and families in a very sensitive area (UN, 1995).

Intimate partner violence (IPV), gender based violence (GBV) and sexual gender based violence (SGBV), which will be used interchangeably for this paper's purpose are now known to be both a serious and a widespread world public health problem (WHO, 2010). According to the WHO, women from different countries between 15 and 49 years old experience physical and/or sexual violence anywhere between 15 to 70%. IPV includes: sexual, physical, psychological and emotional abuse occurring in women at the hands of men (WHO, 2010). Human rights are violated with these crimes and the damage impacts not only individuals, mainly women, but families including young children.

WHO defines IPV as a behavior by an intimate partner or ex partner that causes physical, sexual or psychological harm, including physical aggression, sexual coercion, psychological abuse and controlling behaviors (WHO, 2010). The Ugandan Readiness Assessment Report defines GBV as a term used to distinguish common violence from violence that targets individuals or groups of individuals on the basis of their gender. It includes: acts that inflict physical, mental or sexual harm or suffering, threat of such acts, coercion, and deprivations of liberty, directed to an individual on

basis of their gender (WHO, 2014). Gender inequality, which is often the cause of IPV, is the inequality in power dictated by gender norms and cultural roles, laws and economic factors as well as inequality in resources and decision-making (WHO, 2014).

Multiple acute and chronic health problems occur with violence including: gynecological problems, psychological complications and possibility the increased incidence of HIV/AIDS occur with physical/sexual violence. Other serious problems that can occur with violence encompass death, unintended pregnancies, induced abortions, sexually transmitted diseases, stress disorders and harmful use of smoking, alcohol and drugs.

Many factors, such as gender inequality, social norms toward masculinity; attitudes of beatings, economic inequality has prevented changes to occur in IPV. Research in this area also has been limited possibility secondary to reporting and sensitivity of the subject. With better research and data collection and examining the social norms GBV may be lowered. Violence can be prevented and the WHO uses an ecology systems model to address the problem by addressing the individual, relationships, community and society.

Background

The WHO is an intergovernmental organization within the United Nation concerned with health and welfare that is made up of a body of 184 nations. Its headquarters is located in Geneva, Switzerland and further divided into six regional offices, divided into sub-regional offices and finally country offices. This paper was done in the country of Uganda in the city of Kampala at WHO's country office.

WHO has several programs related to health from sanitation, immunization, non-communicable and communicable diseases to reproduction. The body of the WHO investigates epidemiological problems, provides technical support, recommends

health regulations, provides information and counseling on health matters, and monitors and assesses health trends (WHO, 2014).

One of the major health issues the WHO has tried to prevent and make recommendations on is in GBV. Violence and violation of women's rights include: physical, verbal abuse, child abuse, trafficking, maiming, rape and marital rape, female genital mutilation, defilement, incest, forced sodomy, sexual exploitation, forced and early marriages, prostitution and sexual harassment. The results of violence have long -term lasting effects on women and long-term consequences for the children and families as well as communities and the society at large.

This has been clearly verified by studies that show that patterns of repeated abuse continue through generations (WHO, 2013). Children exposed to violence are more likely to be abused themselves, not receive health care and have behavioral, emotional and school problems. In older children such as adolescents they are more likely to drop out of school, smoke, have unsafe sex and use alcohol and drugs (WHO, 2014).

Mostly, though definitely not all, violence against women is propagated by intimate partners. According to reports from the Ministry of Education in Uganda, male teachers also have a high incidence of abusing children. Often times, though teachers are not reported because then children will not have teachers in their schools especially in rural areas. Children and adults both are reluctant to report these cases to the local authorities. This then creates a pattern of continual abuse.

Throughout the world, the most common violations against women are by intimate partners or intimate partners of the past. (WHO, 2013). Approximately, 27% of women in Europe and 46% in Africa have experienced IPV (WHO, 2013). In younger women of 15-19 years and 20-24 years, the prevalence is 20% and 32% respectively (WHO, 2013). Some facts from the WHO state women who have

experienced violence are 2-3 times more like to use alcohol and 2.6 times more likely to experience depression or anxiety (WHO, 2013).

Not only are GBV women impacted by a possible increase of HIV/AIDs and other sexually transmitted diseases but violence increases the risk of suicide, reproductive health problems, fatal and non-fatal injuries, induced abortions and mental health problems to name a few health problems. Violence on women and violation of women's rights has demonstrated incidences of lower birth weight for the children and increased incidence of diarrhea, fewer vaccinations and other childhood diseases.

In a 10 country survey, conducted in 2006 called Prevalence of Intimate Partner Violence the findings from the WHO, a multi-country study on women's health and domestic violence, found that in countries such as Peru, Bangladesh, Tanzania, Ethiopia, Thailand, Brazil, Namibia, Samoa, and Japan showed between 10-50% of IPV (Garcia, 2006). In countries, such as Ethiopia, showed an incidence of 59% for physical violence. For the combination of sexual and physical violence Japan incidence was around15% and 71% in Ethiopia with Tanzania, Bangladesh and Peru not lagging far behind (Garcia, 2006). Interestingly, most cases of abuse were repeated offences. Controlling for repeated behavior was highest in Tanzania with over 90% of women reporting this fact. This study also showed that men experience violence against strangers but women are more likely to experience violence with intimate partners (WHO, 2013).

The summary of the studies by Garcia and the WHO show that violence against women is present in many cultures and geographical areas and Uganda is not an exception (Garcia, 2012). Rakia, in the southwest part of the country of Uganda and in some parts of northern Uganda there was reported 64% and 61% respectively, of IPV among women between the ages of 15-49. Pentecostal believers, rural inhabitants and the poorly educated women also show a high incidence of IPV.

Multiple studies state women who have experienced violence or witness violence in families and who have sex at a young age are more likely to have intimate partner violence (Garcia, 2012). Another added fact shows that men who also have witnessed violence at a young age and have a high rate of alcohol are more often penetrators of violence (Heise, 2011). Violence occurs more often when there is less education, more than three children, and poverty. Family abuse, such as seeing the father abuse the mother, contributes more abuse with both genders. A man witnessing their own fathers beating the mothers is more than twice to be guilty of the same crime, especially at a younger age. There is a higher risker of STI and HIV in women who have been abused because husbands often have more than one partner.

In Sub-Saharan African countries, the statistics show that higher incidence of abuse occurs when women have more than three children, husband's alcohol abuse, and working and lower education. Also, the longer couples have been married the more likely there will be abused. Abusive men have similar characteristics such as: having more than one wife, alcohol abuse, witnessed their mothers being abused and feelings that it is acceptable to hurt a woman. Seeing their mothers abused sets up both men and women to accept the attitudes that abuse is acceptable. This attitude and perception allows abuse to continue to be unabated.

One of the most interesting aspects of violence against women is the attitude both women and men have in regards to women experiencing violence. Both sexes, in some areas of Uganda believe that women deserve beatings (WHO,2012). Demographically, women in rural areas are more likely to have positive attitudes toward wife beating.

Studies show women making decisions without consulting husbands, often leads to more abuse (WHO, 2012). Both women and men believe attitudes toward wife beating as the norm in some cultures. Having no children and having no religious

beliefs leads to a more negative attitude toward wife beating. Traditional gender roles have been shown need changing in order for behaviors to change.

In justifying reasons for beatings the women stated that if they neglected their children or went out without informing their husbands violence was justified in over 50% of the cases (Heise, 2011). Arguing with the husband is often a reason for partner abuse. Interesting, though in studies on abuse 59% of women reported abuse and only 39% of men reported being an abuser sowing the perception of abuse is often skewed.

Pregnancy is a contributing factor to violence. And with that come low birth weights, more diarrheal diseases of children and less immunization. Many studies have been completed showing the severity of women's health problems related to pregnancy increase at this time. Pregnant women who have been abused have more incidences of ruptured membranes, anemia and have children with lower birth rates.

Gender inequality is the imbalance in power dictated by gender norms, cultural roles, laws and economic factors. The imbalance of power in decision-making has a direct effect on whether a woman gets infected with HIV/AIDS, as women have no negotiating power over sexual choices. Women cannot negotiate the use of condoms, when to have sex, and or husband's having multiple partners resulting in unequal resources to seek care when HIV or STI's occur. Several studies by the London Tropical School of Medicine indicate that HIV occurs more frequently in women who have been abused but it is a complex problem for both women and men (Campbell, 2014).

Uganda is a country of approximately 36 million people with over 80% of the people living in rural areas. The capital Kampala houses more than half of the urban inhabitants. The most recent data from 2011 shows the fertility rate is 6.9 births per woman with the rural areas having the highest fertility rates. The most recent survey

done in 2011 by Uganda Demographic and Health Survey showed in almost 50% of women and close to 60% of the men witnessed their father beating their mothers. Additionally, 44% of women who experienced some type of abuse never sought any type of health care. This affects them mentally and emotionally as the pain and the trauma of abuse is buried within them. This has the potential to affect their health and general well being.

In Uganda, approximately 50% of men are polygamous with 2-3 wives. Literacy runs as high as 40% in women especially in rural areas. Thirty-nine percent of women have no education in the northern region. Women are employed more than men but 21% have not been employed in last 12 months and most women in rural area are self-employed.

Other health consequences showed that in Eastern Uganda IPV is associated with an increased risk of attempted suicide. A cross sectional study in Northern Uganda, found women who have ever experienced rape or sexual abuse were 1.7 times more likely to have post-traumatic stress symptoms compared to those that have not suffered abuse. They were also reported to have more STI's and 1.3 times more likely to have experienced a non-live birth. During pregnancy they were more likely to develop obstetric complications such as hypertension, premature births, and obstructed labor.

The reasons for emotional abuse women experienced included; talking to other men, meeting friends, unhealthy control where the man wants to know where the woman is at all times, or visiting relatives without the husband's permission. Violence also occurs to people women love such as the children or other family members (WHO, 2011).

Women feel helpless with partner violence because it is considered a private matter so the law will not get involved. Reasons for not leaving the marriage after they have

been abused are the children, protecting the marriage and the family will not take them back. Women are often poor and don't know if they will survive on their own. They know it will be costly if they leave and there are no safe exit plans, escape routes or safe houses. There are very few resources for abused women. Often times, health facilities are ill equipped to care for abused women and thereupon, they do not seek any type of care (Appendix 2 and 3).

Another factor that came up on a recent conference in Uganda on IPV in Tanzania, Kenya and Uganda is the necessity or importance of routine screening of abuse in health care facilities. Screening for health problems such as PSA for prostate cancer or markers for heart disease has been debated in the same way as screening for abuse in women. GBV screening in a study from Kenya showed it was important and demonstrated good results as long as privacy or confidently were upheld. (Jewkes, 2013.)

Another element to observe in IPV is the economic consequences. In Uganda, the data shows staggering annual costs to survivors and their families and services. This study may be limited because only one-third of women seek counseling. Direct costs such as police service, health care and local council is estimated at $7.8million (WHO, 2013). Lost earnings were estimated to be close to a million dollars. The WHO and the Ministry of Health recognize the seriousness of this problem and countries are now passing laws to criminalize predators and provide services including: legal, health and social needs for the victims.

Several important institutions, such as, the UN and some of its specialized agencies like the WHO, UNICEF and the Government of Uganda, are recognizing the impact of GBV, which affects mostly women but not excluding men, affects them all economically, socially, psychologically, and physically. According to the WHO,

GBV is a violation of women's human rights and causes major health problems (WHO, 2013).

The constitution of Uganda has been set up as a duplicate of several international human rights treaties and bills that promote security and elimination of abuse against women. The country has enlisted many bills and policies including: The Domestic Violence Act and Domestic Violence Regulation, The Uganda National Clinical Guidelines for management of Sexual and Gender-Based Violence Survivors, and the Prevention of Trafficking in Person Act.

Implementing of the project

Uganda government recognizes that 68% of married women have experienced some kind of violence. A recently written readiness assessment report for addressing gender based violence has led to development of a training manual for health care workers on the management of sexual gender-based violence survivors/victims. The manual will be used along with a power point presentation in a weeklong training program for health care workers this fall. The purpose is to teach health workers to be able to respond to major conditions related to violence especially gender based violence.

Another program to instruct health care workers, three years ago, was implemented but I was unable to locate the teaching materials for this course. In 2013, WHO and the Health Ministries of Health and Gender identified the stakeholders to coordinate efforts, identify challenges and gaps with gender based violence prevention and response and discuss how WHO might support and build on already existing efforts. By examining the Readiness Assessment Report for addressing gender based violence many recommendations were made (WHO, 2013). One of the major recommendations was the need for the health sector to mobilize more resources in order to operationalize the different policies, equip health units and build local

capacity to implement GBV programs at a wider scale. The Department of Reproductive Health of the WHO in Kampala, Uganda was able to address the seriousness and prevalence of the health problem facing this country on GBV, though admittedly studies were limited. The goal of the agency is to reduce and prevent IPV. One of its goals was to strengthen the role of the health sector in prevention response to violence against women and thereupon, the training program was established.

From this meeting evolved a manual for training health care workers on management of Sexual Gender Based Violence. The manual and the power point presentation have a three-fold purpose.

1. To provide the ministry of Health with National Standardized material for training nurses, midwives, medical officers, clinical officers and other relevant stakeholders involved in the management of SGBV survivors/victims.
2. To provide a training resource for all players in health institutions and organizations involved in training service providers in management of survivors/victims of sexual gender based violence as a component of the Minimum Health Care Package.
3. To serve as the basis for teaching nurses, midwives, clinical officers, medical officers and other health professional trainees so as to respond appropriately to major conditions related to Sexual Gender Based Violence (WHO. 2013)

There were four broad training objectives: develop knowledge and skills of health workers in SGBV management and response; equip health workers with abilities to establish and maintain linkages/partnerships for SGBV; provide health workers with knowledge and skills to conduct appropriate referral and manage SGBV data; and familiarize health workers with procedures and requirement to facilitate legal redress for SGBV victims.

The training is to begin in one month. In the previous training, 3 years ago, ten districts were utilized for preventions. The new training is expanding from 10 districts but it was unclear how many districts would be trained.

My role for this internship was to read, rewrite, edit, and make suggestions on improvements on the manual and power point presentations. I was also tasked to write strategies and recommendations on how to implement these programs.

By recognizing the cultural factors (see Appendix x) and the fact GBV or IPV affects not the individual, but relationships, the community and society at large the WHO has adopted an ecological framework. This framework looks at the individual, who may be either a victim or perpetrator of violence; relationships who are the peers, intimate partners and family with an interconnection of behaviors and experiences; the community referring to social relationships such as schools, work environment, neighborhoods, health facilities, churches who form social networks of the victims; and societies which are the influences on victims of violence and penetrators who are influenced by: gender equality, religious or cultural systems, economic or social policies that causes conflict between different groups(WHO, 2013) (Appendix 5). The CDC stresses the fact that to prevent sensitive issues like sexual violence or any type of violence one must understand the risk and protective factors (CDC, 2002). By looking at the inclusion of all domains the risks: prevention and interventions can be most effective (WHO, 2013).

As the model suggests, all must be involved for prevention to occur, therefore. in Uganda both the Ministry of Health and the Ministry of Gender and Ministry of Non-Communicable Diseases are working to prevent this problem along with the assistance of the WHO. Together they have set up policies and helped in producing the training materials.

The training materials for management of GBV and readiness assessment report

are both to identify challenges and gaps with gender-based violence prevention and response. By strengthening the role of health sector, this may help the prevention and response to violence against women.

My fieldwork for this project consisted of a literature review to try to assess the seriousness of the problem both worldwide and in Uganda. The training manual for Management Gender Based Violence was reviewed and revised. The power point presentations were also reviewed and amended. I also tried to access other programs that have been developed by the WHO in Uganda and evaluate their successes but I was unable.

Lastly, recommendations for strategy and policy were written (see below) and given to the Director of Reproductive Health, who I interned with during this project. This paper will be given to the Director of Reproductive Health along with the materials that were reviewed.

A couple of the Terms of Reference for this internship are listed below that I believe I was able to complete were:

4. Participate in meetings and planned activities for Joint Program on Gender Equality s assigned by FRH team and generate reports.

5. Familiarize her with the activities of the two programs through reading the guiding documentation.

Results

One successful program by a non-government organization (NGO) called SASA with Sexual Violence Research Agenda conducted a cluster randomized trail to assess the impact of a community mobilization intervention to prevent violence against women and reduce HIV risk in Kampala, Uganda from 2007-20012 (Appendix 4). The results of this study showed that interventions did decrease acceptance of IPV among both men and women and the right to refuse sex.

The four-step plan has been added to demonstrate the model of this program (see Appendix). The women also experienced less violence and more community support was utilized (Ambrasky, 2014). More successful plans for women who have experienced violence were more difficult to find.

The readiness assessment report, with a group of governmental and nongovernmental staff, has identified the problems related to GBV. They have also included many other stockholders in the project. The difficulty with IPV is first evaluating the data itself since there are very few studies. In Appendix , we can see that from 2006 to 2011 the percentage of ever-married women aged 15-49 who have ever experienced physical and/or sexual violence was down in most areas except in Kampala, the North and Central 2. I was again unable to evaluate what brought about changes in the communities because data was strictly taken from Uganda Statistical Survey 2011.

The overall training materials, for management of sexual violence, needed quite a bit of rewriting and editing. It was a bit laborious to get through some of materials so the trainers could better utilized management of SGBV. The power point presentations (example: Appendix 6) also needed some editing and might be difficult for students to read but it seems here in Uganda that is how many power points are written. I have enclosed one of the power points so one can see the examples. I did not try to make major changes to the power points because of the limited time and other's input. The biggest suggestion I could contribute to the teachings was to employ more participation from the health care workers during this course. Many of the health care workers may have been abused them by looking at the statistics and the number of health care workers that are women. People are more than willing to share when in a safe environment and this course may allow this to occur. Focus group discussions (FGD) may be utilized at the beginning or/and of each session.

Even though more studies need to be done to have a clearer data a basketful of information of the gravity of the situation is known. As mentioned, locations, the risk groups and risk factors are known as seen in the records (see appendix's).

An evaluation tool and follow-up on both the effectiveness of the program seems to be lacking in the program. A plan to evaluate the course, in 3, 6, 12 months is a recommendation. The other recommendation is for a survey to be conducted in one year to evaluate if violence has changed and if the treatment program is effective.

Screening was discussed at great length at the conference August 11-12th in Kampala for Intimate Partner Violence. There are many screening tools in the literature with an excellent one by the CDC that could be easily utilized. The manual does have an annex for comprehensive emergency care for survivors of sexual violence that is a good beginning and could be revised and be used as a screening tool. This is of utmost importance during antenatal screen since pregnant women and their children are a risk for violence and complications.

After talking to the Health Minister of Non-Communicable diseases it was noted that injuries are under his department, which would include injuries from intimate partner violence. Thereupon, one of my recommendations is to verify both data collection and teaching materials be shared with the both the Minister of Non-communicable diseases and Minister of Reproductive Health and Minister of Gender. The organization of the WHO here in Kampala with the two departments of reproductive health and non-communicable disease can make an effort to work more closely together with one another. Also, in a country like Uganda where so many NGO's exist with little coordination among one another, a bridge needs to be built between government and non-government organizations. Programs like SASA, who have shown success, need to be incorporated with a programs like what the WHO has

developed. It seems this has begun by both the recent conference on IPV and the readiness assessment this past year.

Lastly, because women and men also utilize beauty and barber shops (open as late as 11.00 pm) shops could be utilized with posters or even support groups to discuss and receive needed support. This could be done in both the rural and urban areas. Support groups are badly needed on these issues and these locations as well as churches may be utilized along under the direction of health care workers. Safe houses are also lacking in this country. If we are training health care workers their role may be to expand to health teaching in other locations where individuals or groups gather. These locations, such as beauty shops are also ideal locations for empowering women and in my opinion are under utilized.

What works in evaluating violence also is the evaluation of gender roles, how laws play out in protecting women and women's perception of their safety play. More needs to be done to incorporate these issues. The training of police with a course similar to what the WHO has complied for health care workers could be the beginning. Men and women both, in the police force, may be first responders for IPV and need to have training to deal with individuals and families.

Another program I attended was on menstruation and keeping girls in school. Through programs, like this, we are empowering woman especially in trying to keep girls in school. The studies and statistics all point to the fact that less education and poverty contribute to violence. By working on ways to keep girls in school, hopefully, will prevent violence but also empowering women to set up better equality among the sexes.

To summarize some of the recommendations for this issue are:

1. To utilize and evaluate a screening tool for gender violence for women between the ages of 15-49 and especially at antenatal visits.

2. Incorporate teaching and support groups about violence in other locations like barbershop and beauty shops.
3. Develop evaluations for follow-up of training programs for health care workers.
4. Evaluate the data on incidence of violence on women who have been exposed to violence in the past after being evaluated.
5. Engage Health Ministry of Gender, Reproductive Health and Non-communicable disease for consistency in planning and prevention as well as the similar departments at the WHO and non-governmental offices.
6. Involve NGO and governmental programs for data analysis, prevention and program planning, financing and technical support.
7. Standards of Operations (SOP'S) for behavioral and structural interventions in health clinics for gender based violence.
8. Analyze the opportunities to coordinate or collaborate across countries to improve IPV prevention in the region.
9. Incorporate training on IPV in both medical schools and nursing schools.
10. Utilize other programs such as keeping girls in school to form equality for both sexes.
11. Plan training for the police force similar to programs similar to the program for health care workers.
12. Include men in teaching programs especially prenatal and post natal care.
13. Engage the ecology model for involving the families and communities by utilizing sources like the media, especially the radio and newspapers text messaging.

Analysis

This is a huge public health program that needs to be addressed from many angles. The role of the health sector can be used to share knowledge and raise awareness and this program for management of sexual gender-base violence is a huge step to begin to address this serious issue. A program, like the one developed by the WHO, can begin to address both the acute problems as well as the long tem affects. The numbers speak for themselves of the occurrence, prevalence and consequences of this public health problem. By developing awareness of the health care workers, this begins to raise knowledge also of individuals, families and communities and eventually the society at large. By identify the nature of the problem(s) through valid research effective programs can be developed and better data can be analyzed and evaluated. Therefore, better policies and strategies can be tackled and even better programs and skills will be developed. If awareness, programs, policies, plans and evaluations are not developed the cycle of violence can never be broken. This will create better outcomes for individuals and families and communities, especially for women and children. Since this problem is a huge cost to society preventing and stopping violence is an investment for all.

One of the most important lessons learned is more research needs to be continued. More data needs to be obtained both pre and post programs. Agencies need to be willing to share information and successes and failures. More educational tools need to be included in medical training for both doctors and nurses. According to the Uganda Minister of Non-communicable diseases, training for these issues are beginning especially in medical and nursing schools. Cultural differences needs to respected but women need to be continually empowered and gender inequality diminished. All other recommendations were addressed above.

These are still some of the questions I still felt have ben left unanswered and even though they could be put in the recommendations I will only make ask these question to trigger thoughts on this issue.

Competencies Addressed

These are four out of five terms of recommendation that I was able to accomplish in the short time I was at the WHO, a total of five weeks.

2, Attend meetings at the Ministry of Health and other Ministries in regard to the Joint Population.

3. Summarize activity reports to reflect on program progress and achievements for the period of April, May, June, July, August, 2014.

4. Participate in meetings and planned activities for Joint Program on Gender Equality assigned by FRH team and generate reports.

5. Familiarize her with the activities of the two programs through reading the guiding documentation.

The first two terms were limiting though I was able to schedule two meetings with the Minister of Non-Communicable diseases and the spoke several times with the doctor in charge of this department at the WHO as well as the director of reproductive help who guided me through this process. Injuries are included in this department of non-communicable diseases so any issues related to GBV must be identified. It was my observation the department of reproduction and non-communicable diseases(NCD) at the WHO need to work closer together to form policies and make recommendations.

Going to the two day conference on IPV was enriching and helped me thoroughly to evaluate the manual and power point as well as compose this paper. It was also informative talking to other individuals who participated in writing this manual and

other individuals and stockholders who are either conducting research or are participating in programs.

The course that helped me form concepts was the core course of Social Behaviors by understanding models especially the ecology model used by the WHO for this issue. This model fits this issue(s) perfectly and it was helpful to have been knowledgeable about this theory especially when it fits this gender based violence perfectly. IPV is never an individual issue and affects not only families and communities but the society. With the high incidence of GBV in Uganda the ecology model is an appropriate theory so no one is left behind in practice, research, policies and treatment.

Global health was another class that helped especially when it came to understanding the Millennium Global Diseases (MGD) which are used religiously by the WHO and other governmental offices especially for the needs and problems of developing countries. After doing my paper for that class on the Democratic Republic of Congo, it made it easier and more understandable the problems of countries in this region. It also helped me understand the health care needs and practices and lack of good research especially for NCD. As far as other core competencies, the importance of biostatistics and epidemiology assisted in multiple ways since understanding the data and prevalence and occurrences of this problem. They also gave me a critical eye on how to look at problems of diseases as well as the importance of valid research.

Sexual Health was another course which helped especially the differences in sex and gender and issues related to HIV/AIDS. Sexual issues are often a sensitive issue for cultures and information obtain in this class made the issues not only easier to understand but to be comfortable discussing these issues. It was interesting several times in groups, when homosexuality was discussed men and sometimes women

would laugh at matters related to this group. I don't think I would have at all understood the cultures viewpoints without this class. Even the laws of homosexuality in Uganda were easy to discuss with individuals on their beliefs to assess others opinions.

The course of Mental Health also helped in relating to issues and beliefs of different cultures. It also helped in reading about the affects of GBV and the needs of women in this country not only on treatment of GBV and IPV but the concerns of gender inequality.

I did feel through the course work could had courses on policy writing to help in this fieldwork. I think it was helpful to see the differences between governmental and nongovernmental agencies functions from all levels and to see the shortcomings and the plusses with both. This could have been discussed more so in one of the courses such as Global Health though I think Social Behaviors did try to stress this fact occasionally. But it was also interesting to see how often times groups do not work together for the same cause especially in a country like Uganda where there is no regulation for NGO unlike countries like Rwanda where there is.

For me, who has been in the field of health for a long time in the clinical aspect and to see how hard but rewarding it is to work on a health problem from a public health perspective but how frustrating as well. It was interesting to see how large organizations like the WHO or Health Ministries operate. I am so glad that I had the chance how an organization functions both at headquarters and in a country. The whole time in Geneva I heard about health Ministries so it was good to observation and talk to Heath Ministries.

Conclusions

My time in Uganda and at the WHO was interesting and fun at the same time. I was very pleased with my project and being exposed to a topic that I knew little about

especially the gravity of the situation. It is definitely a public health problem that needs to be addressed. The ecology model addresses the issue perfectly by looking at all the stockholders not just from one person but the society as whole especially in regards to equality and care. The teaching materials were inconsistent and at times poorly written but other times the material was done quite well. I think it depended on who wrote each section. The most frustrating thing for me was not having better supervising support. It was often like pulling teeth not only getting direction but to obtain information.

It was a real lesson in how to deal with individuals who are in power and the feeling maybe your presence is not wanted. When I am finished with these projects for school I plan on writing up recommendations for interns who come to the WHO in Uganda.

My fieldwork experience in Geneva was less productive though I did manage to put several documents and power point presentations together for NCD. The most rewarding part of Geneva was the multiple talks I attended on HIV/AID, Empowering Women, a talk by Kofi Annam, the health of Portuguese countries, the workings of Ebola and the role WHO plays, partaking and learning how WHO responses to disasters, working on the document for essentials medicines, learning about the health care in Japan, learning about how different departments at the WHO function especially the communication department, TB and reproductive health. It was most interesting to hear about studies being done in health systems and distribution of equipment and other essential tools such as immunizations, in the field.

With all this said, I enjoyed Uganda and felt at the country level one can learn and see how policies and recommendations from Geneva are implemented. I also understand how ministries and organizations work with one another. I only wish I had more time here and to have been able work in other departments to see how they

function. Though I did make a real effort to talk to other department's especially non-communicable diseases, polio and malaria. I learned about communication, policy implementation, course work, and evaluation of teaching materials, assessment and evaluation of health problems and inputs and outcomes that the Masters in Public Health prepared me with their courses.

With this project and the time in Uganda, I learned about the culture, health practices, lack of health care and the overall health problems with lack of resources. I also observed how different organizations tackle the health issues of this country. The 4 conferences I went to were helpful to learn more about public health: Keep the girls in School: Break the silence on menstruation, the policy on scorecards to evaluation care on the national, districts and community level, the conference on IPV and the update on medicines for HIV. Lastly, I enjoy a group of people who were friendly, cheerful, and consistently warm. To them I only can say thanks and how can I ever tell you how grateful I am for this experience.

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TIMELINE
World Health Organization Geneva, Switzerland
June 2,2014 to July 18,2014
Total Hours: 280
Department of Non-Communicable Diseases
Supervisor Dr. S. Mendis

World Health Organization
July 21, 2014 to Aug.22, 2014
Total Hours: 200
Department of Reproductive Health
Supervisor Dr. O Sentumbwe

Master of Public Health Program
Preceptor Evaluation of Student in Fieldwork Experience

The purpose of this form is to provide the preceptor with an opportunity to evaluate the student's performance in the Field Experience. The preceptor and student should review and discuss this evaluation together before it is submitted.

Student's Name: _____ Preceptor's Name: DR OLIVE SENTUMBWE-MUGISA Preceptor's Title: FAMILY HEALTH AND POPULATION ADVISOR

Preceptor's Email: sentumbweo@who.int

Please rate the student's performance during the field experience based on the following criteria:
N/A – Not applicable
1 = Unacceptable at this point in training 2 = Somewhat below expectations
3 = Met expectations
4 = Consistently exceeded expectations

COURSE REQUIREMENTS:	
Achieved Field Experience Learning Objectives (see Field Learning Agreement)	3
Completed defined project in Public Health Practice	3
Worked effectively with Preceptor	3
Worked effectively within Organization	3
Integrated public health theory into public health practice	3
Demonstrated an appropriate level of public health skills and knowledge in field experience	

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PUBLIC HEALTH SKILLS AND KNOWLEDGE:	
Able to apply the core function of assessment in the analysis of public health problems. (Assessment)	3
Demonstrated an understanding of the structure, process, and outcomes of health services including costs, financing, organization, outcomes, and accessibility. (Systems)	3
Able to plan for the design, development, implementation, and evaluation of strategies to improve individual and community health. (Program Planning)	3
Able to use the basic concepts and skills involved in culturally appropriate community engagement and empowerment with diverse populations. (Cultural Competency)	3
Able to prepare a program budget with justification. (Financial Planning/Budgets)	3
Demonstrated an ability to use collaborative methods to achieve community and organizational goals. (Leadership)	3
WORK HABITS:	
Reliable 3 ✓	
Took initiative in work 3	
Efficient 3	
INTERPERSONAL SKILLS:	
Professional demeanor 3	
Interactions with co-workers GOOD 3	
Interactions with community partners WELL DONE 3	

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2. Did the student bring the appropriate knowledge and skills needed to complete the projects (s) in your organization? If no, what additional knowledge and skills were needed? 3 YES SHE BROUGHT SOME GOOD SKILLS
3. What was the student's work helpful or useful to you and your agency/organization? Please explain. 3
4. Please provide additional comments regarding the student's performance.

Final Grade Assigned for Field Experience	(Check One)
A= Outstanding	
AB= Very Good	✓
B= Good	
BC= Satisfactory, but below expectations	

Appendix 1


REGIONAL NEWS
NEW VISION, Thursday, August 21, 2014
Man kills pregnant wife, son and self
NEBBI
By Benedict Okethwengu
A 37-year-old man murdered his son and pregnant wife for allegedly denying him sex.
On Tuesday, Geoffrey Okoku allegedly hit his six-month pregnant wife, Jeres Ngamita and Ivan Mungutimo, Ngamita's child from a previous relationship, with a hoe.
Albert Oryek, a neighbour, said the incident happened at about 3:00am. He said the previous day, he had counselled Okoku over his demands.
"I advised him to calm down because his wife must have had a reason for denying him sex, but I was surprised that he later killed her," Oryek said.
He added that a few hours earlier, Okoku had been in a meeting with elders to resolve the misunderstanding.
Hamilton Okidi, the Nebbi Criminal Investigations Department officer, said Okoku's body was later discovered hanging from a tree at Olyeko village, 6km from the scene of crime.
"We are not proceeding with a case because the suspect is dead," he said.
A Police source, who preferred anonymity, said they are likely to shift
NORTHERN REGION
investigation from the murder to arso
This, he said, is likely to take shap
because several houses were burnt an
property destroyed in a revenge attack b
the family of the deceased woman.
Women activists have condemned t
act, urging the different stakeholde
in Nebbi to ensure that gender-bas
violence is dealt with.
Training of Health Workers on
Management of
Sexual Gender-Based
Violence Survivors/Victims
Trainee Manual

Appendix 2

FIGURE 5

Percentage of ever-married women aged 15-49 who have ever experienced physical and/or sexual violence committed by their current husband/partner in 2006 and 2011, *Uganda DHS 2006 and 2011 (4, 5)*

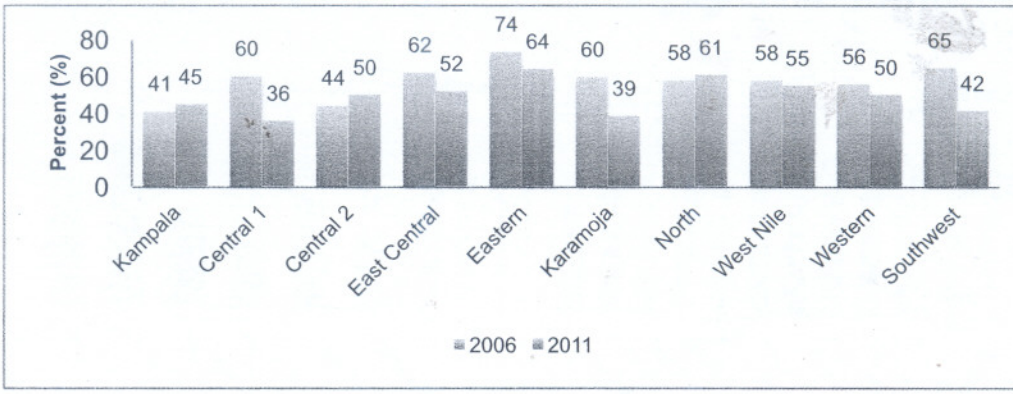
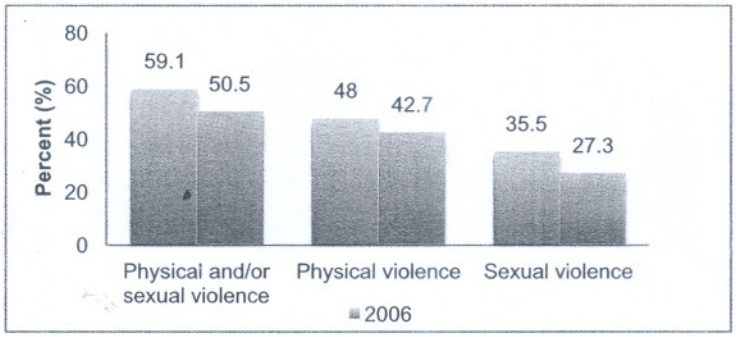


FIGURE 6

Percentage of ever-married women aged 15-49 who have experienced physical and/or sexual violence committed by their current husband/partner in 2006 and 2011, *Uganda DHS 2006 and 2011 (4, 5)*



Risk factors

Analysis of data from the Uganda DHS 2011 reveals a number of risk factors associated with intimate partner violence for being a perpetrator of violence and for those experiencing violence.

For example, currently married women were asked whether their current spouse exhibits any of five controlling behaviours, such as "frequently accuses her of being unfaithful," and "insists on knowing where she is at all times." Data analysis revealed that 71% of women reporting 4-5 of these behaviours had experienced intimate partner violence, compared to 58% who reported 3, 50% who reported 2, 40% who reported one, and only 29% who reported none. These data show that close control and monitoring of their wives' behaviour is an important warning sign and correlate of violence in an intimate relationship.

Appendix 4

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The SASA! Approach: How it works
Start
Awareness
Support
Action
Learning about the community
Selecting Community Activists
Fostering 'power within' staff and community activists
Helping activists gain confidence
Informal activities
Encouraging critical thinking about men's 'power over' women
Strengthening skills and connections between community members
Joining 'power with' others to support change
Trying new behaviors, celebrating change
Fostering the 'power to' make positive change
involving community members, leaders and institutions to build critical mass

Appendix 3

FIGURES 1-4

Percentage of ever-married women aged 15-49 who have experienced physical and/or sexual violence committed by their current husband/partner, by region, ethnicity, religion, and residence, *Uganda DHS 2011(5)*

FIGURE 1

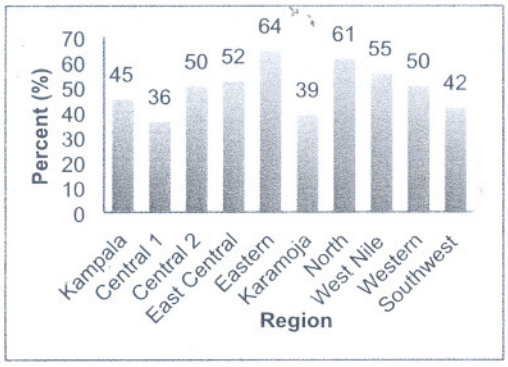


FIGURE 2

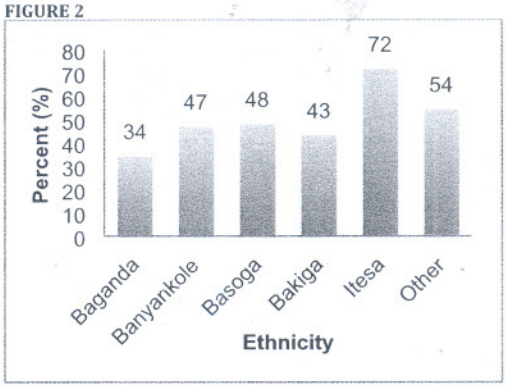


FIGURE 3

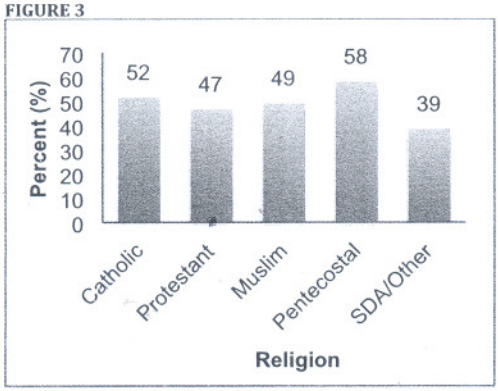
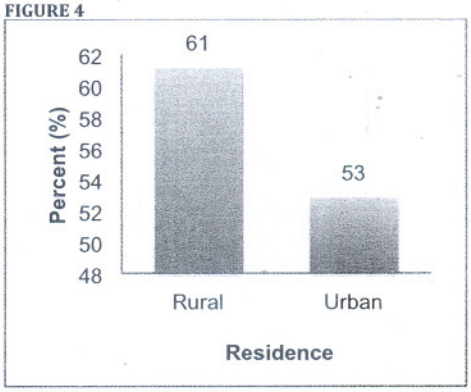


FIGURE 4



Trends in violence against women in Uganda

Prevalence of intimate partner violence decreased between the 2006 and 2011 DHS surveys in nearly all regions, with the exception of marginal increases in Kampala, Central 2, and the North region (**Figure 5**). In 2006, 59.1% of ever-married women aged 15-49 reported having experienced physical and/or sexual intimate partner violence by their current partner; in 2011, this figure dropped to 50.5% (**Figure 6**).

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BOX 1

Cultural and social norms supporting different types of violence

Child maltreatment

- Female children are valued less in society than males (e.g. Peru [*18*], where female children are considered to have less social and economic potential).
- Children have a low status in society and within the family (e.g. Guatemala [*19*]).
- Physical punishment is an acceptable or normal part of rearing a child (e.g. Turkey [*20*], Ethiopia [*21*]).
- Communities adhere to harmful traditional cultural practices such as genital mutilation (e.g. Nigeria [*22*], Sudan [*23*]) or child marriage (*24*).

Intimate partner violence

- A man has a right to assert power over a woman and is socially superior (e.g. India [*8*], Nigeria [*9*], Ghana [*25*]).
- A man has a right to "correct" or discipline female behaviour (e.g. India [*26*], Nigeria [*27*], China [*28*]).
- A woman's freedom should be restricted (e.g. Pakistan [*29*]).
- Physical violence is an acceptable way to resolve conflicts within a relationship (e.g. South Africa [*30*], China [28]).
- A woman is responsible for making a marriage work (e.g. Israel [*31*]).
- Intimate partner violence is a taboo subject (e.g. South Africa [*32*]) and reporting abuse is disrespectful (Nigeria [*9*]).
- Divorce is shameful (e.g. Pakistan [*11*]).
- When a dowry (financial payment from the bride's family to the husband) or bridewealth (financial payment from the husband to the bride's family) is an expected part of marriage (e.g. Nigeria [*27*], India [*33*]), violence can occur either because financial demands are not met, or because bridewealth becomes synonymous with purchasing and thus owning a wife.
- A man's honour is linked to a woman's sexual behaviour. Here, any deviation from sexual norms disgraces the entire family, which can then lead to honour killings (e.g. Jordan [*34,35*]).

Suicide and self-harm

- Mental health problems are embarrassing and shameful, deterring individuals from seeking help (e.g. Australia [*36*], Brazil [*37*]).
- Individuals in different social groups within society are not tolerated – e.g. homosexuals (Japan [*38*]).

Sexual violence

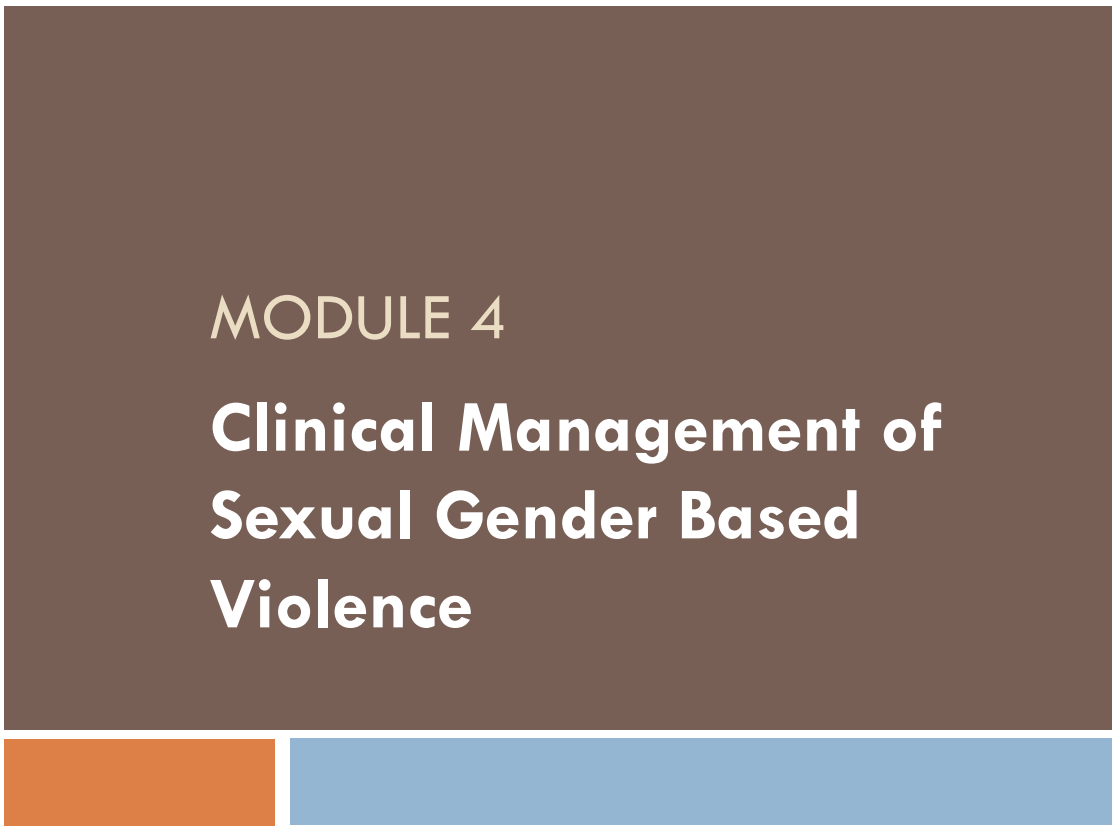
- Sex is a man's right in marriage (e.g. Pakistan [*11*]).
- Girls are responsible for controlling a man's sexual urges (e.g. South Africa [*10,39*]).
- Sexual violence is an acceptable way of putting women in their place or punishing them (e.g. South Africa [*10*]).
- Sexual activity (including rape) is a marker of masculinity (e.g. South Africa [*39*]).
- Sex and sexuality are taboo subjects (e.g. Pakistan [*11*]).
- Sexual violence such as rape is shameful for the victim, which prevents disclosure (e.g. the United States [*12*]).

Youth violence

- Reporting youth violence or bullying is unacceptable (e.g. the United Kingdom [*40*]).
- Violence is an acceptable way of resolving conflict (e.g. the United States of America [*41*]).

Community violence

- Cultural intolerance, intense dislike and stereotyping of "different" groups within society (e.g. nationalities, ethnicities, homosexuals) can contribute to violent or aggressive behaviour towards them (e.g. xenophobic or racist violence [*42*] and homophobic violence [*43*]).


MODULE 4
Clinical Management of Sexual Gender Based Violence

Appendix 6